COVERED SERVICES

An ambulatory surgery center (ASC) is a certified, free-standing facility that operates exclusively for the purpose of furnishing outpatient surgical services.

AHCCCS reimburses the ASC a facility fee for services listed on Medicare's free-standing ASC coverage list. The facility fee covers all services provided by the ASC in connection with rendering surgical procedures, including but not limited to, nursing services, medical supplies, equipment, and use of the facility.

GENERAL BILLING AND AUTHORIZATION REQUIREMENTS

- ☑ Ambulatory surgical facilities furnishing non-emergency surgical services must obtain prior authorization from the AHCCCS Prior Authorization Unit for scheduled ambulatory surgery except voluntary sterilization procedures.
  - ✓ The PA for the ASC is separate from the surgeon's PA.
- ☑ ASC-covered surgical procedures must be billed on the CMS 1500 claim form.
- ☑ Each of the approximately 2,400 surgical procedures on Medicare's free-standing ASC coverage list is classified into one of eight payment groups.
- ☑ Reimbursement is based on the payment rate for the group into which the procedure is classified.
  - ✓ Medicare reimburses free-standing ASCs in Arizona based on locality -- Phoenix, Tucson, Yuma, and all other areas of the state.
  - ✓ AHCCCS reimburses the Phoenix rate for all free-standing ASCs.

BILLING AND REIMBURSEMENT OF MULTIPLE SURGERIES

- ☑ The ASC must bill the principal or primary procedure (the procedure in the highest payment group) on the first line of the CMS 1500 when multiple procedures are performed on the same recipient on the same day or at the same session.
  - ✓ If an ASC does not identify the primary procedure, the AHCCCS system will identify the first procedure listed on the claim as the primary procedure.
- ☑ Reimbursement of the primary procedure will be at the lesser of billed charges or the capped fee for the payment group.

BILLING AND REIMBURSEMENT OF MULTIPLE SURGERIES (CONT.)

- ☑ Additional or secondary surgical procedures (procedures in lower payment groups) should be billed on subsequent lines of the CMS 1500 using modifier 51 (Multiple Procedures).
  - ✓ If an ASC does not identify the secondary surgical procedure(s), the AHCCCS system will identify the primary surgical procedure and assign Modifier 51, as appropriate, to a maximum of four of the next surgical procedures listed on the claim.
- ☑ AHCCCS will reimburse each of the first four secondary procedures at 50 per cent of the capped fee for the payment group or the billed charge, whichever is less.
- ☑ Claims with more than four secondary surgical procedures will pend to the AHCCCS Medical Review Unit.

BILLING AND REIMBURSEMENT OF BILATERAL PROCEDURES

- ☑ A bilateral procedure performed in one operative session is reported using Modifier 50 and is subject to the multiple surgery reduction.
- ☑ A bilateral procedure is reimbursed at no more than 150 percent of the rate for the payment group for that procedure.